Meeting Minutes

December 18, 2014 10:00am To Noon

DCF Learning Center, Room E, 2600 SW East Circle Drive, Topeka, KS 66606

Those in attendance:

Russell Nittler, Marilyn Kubler, Kelley Melton, James Bart, Kerrie Bacon, Ed Nicholas, Victor Lopez, Kelly Smith, Njeri Shomari, Janice Storey, Barb Conant, Eric Harkness, Aldona Carney, Joe Ewert, Greg Wintle, Ted Jester, Liz Long

Review of Minutes from Last Meeting:

Russell Nittler, KDHE

Russell stated that if anyone has any changes to the minutes to send him an e-mail. Once the minutes are approved, then we upload them to the website. Filled in the missing name then approved. September 2014 minutes are on the website now.

KanCare Open Enrollment:

Russell Nittler, KDHE

Once a year when an individual is enrolled in KanCare they go through open enrollment period where they can change their KanCare health plan. A large majority of those are happening right now because the people who came on KanCare in January of 2013 come up for open enrollment at the same time. If people were approved for KanCare later than January of 2013 their open enrollment is their yearly anniversary date of getting approved of KanCare. Currently back in November we mailed out 165,372 of these packets. The packet on the e-mail was broken up. The people in the room have a packet that an actual person would receive. 160,310 of these packets were mailed out in English and 5,062 mailed out in Spanish. Individuals should have had these packets by December 1st. They can call into the HP Center in Topeka and change their plan for January. After January is when the 60 days start for them to change their plan. They can change as many times as they want during this period as they like. But, after that period is closed they are with that plan for the next year. They will have until March 4th to call in and change their plan. That plan takes affect the month after they call in. If they call on January 15th their MCO plan would change February 1st. The first packet is the annual enrollment letter. I have heard from a few people say they only have a choice of two health plans and if you look at the annual enrollment letter it says what their current plan is and then there are the other two they can choose from. If they do nothing with this packet they just stay in the same plan they were in last year. The next letter in the packet is the open enrollment letter that tells them the three ways they can change their plan. That is either online at the KMPA website, return the enrollment form, or call the enrollment center at 866-305-5147. They can call the enrollment center to receive the plan provider list or they can go online to each of the MCO's and look at that information online. The next letter in the packet is that American Indian Native Alaskan opt-out process. For Kansas residents that are a member of a Federal recognized tribe can opt-out of KanCare once they verify their tribal membership. That means they would get a white plastic medical card that says KDHE on it. They would be treated as a fee-for-service person. They can opt in and out throughout the year at their desire. If they are opting-out they do not get to have the value added services that the plans provide. The next item is the enrollment booklet. This is sort of new this year; they shrunk it down for mailing purposes. In here it has their rights, responsibilities, repeat of how to make the change, how to file grievances and appeals, State Fair Hearings, and phone numbers. There is also a health plan program highlight for 2015. These are the value added services that the MCO's provide above and beyond what Medicaid provides. The open enrollment packet also includes three colored flyers each one from the MCO and it is their packet sales pitch for that and then the self-addressed envelope. Are there any questions, concerns, or statements about open enrollment before we move on?

KanCare Ombudsperson Report

Kerrie Bacon, KDADS

The quarterly report is in three parts. The first part is about Accessibility that is on page one. You can see that for 3rd quarter I had 526 contacts and 256 of those were MCO related. A new piece of information that was added shows the contacts by quarter for 2013 and 2014. 3rd quarter was up compared to 2nd quarter this year and 3rd quarter last year. A new resource that was added that I shared at the prior CSI meeting was the medical assistance information. For those of you who were at the prior meeting it had to do with medical doctors, vision, pharmacy, and dental assistance for people who did not have insurance or had high spend downs that might need access for low or free assistance in the community. That is out on the website; when people call and ask for this information I print it off and mail it. Either they don't have a computer or they don't have a printer in their home. I am not going to go through the outreach information it is printed there if you want to read through that. The data information is the other piece that is new. We have the new tracker in which we were able to start adding new information for everyone. On the first piece under data the new information shows the sub-collar type. Under consumer we are now tracking whether it is home and community based related or if it is long-term care related. So you can see that we usually have more that are community home based related than we have long-term care related. Russell asked, so would that 371 be pregnant women, children, and low income families? Kerrie said, yes, or it is people who are not identified as something. Russell stated, that is quite a few. So it could be elderly with spend down or people who get an SSI check that just have their eligibility. Kerrie stated, yes, people call me for all different things. Under contact information I am now reporting response information. It is showing what has been responded to and what has been closed. At the time this was pulled we were at 86% closed for 3rd quarter. We had 73 cases that we were still working on for 3rd quarter. The information underneath there shows that we had an average number of days to resolve an issue was 9 and 246 of the 526 files were resolved in a day or less. A zero day means that same day, one day means it took us basically two days to turn it around. It may mean I did not call them back until the next day. If you look at page 3 the issues are still the same, it is still the same 20. The topic 4 concerns for 3rd quarter are appeals, grievances, home and community based services, general issues medical service, and billing. The chair for the Bob Bethel KanCare Oversight Committee had asked me to give some specifics about the appeals and grievance issues. This next sentence was specifically information for that request. Of the appeals and grievance issues only 1 of the 46 was a grievance. 3 were for Amerigroup, 31 for Sunflower, 5 for United, and 7 were not identified to a company. A participant asked, can you tell us what the calls were generally with the appeals, were they just I/DD or everything? Kerrie stated, these are for everything. The participant then asked if an I/DD has an appeal is there any way we can see how many I/DD appeals there were? Kerrie stated, I may be able to help you how many were I/DD. Participant: Also, what their appeals were generally. Another participant asked if we can have that broken down by waiver because I would be interested in having that for the Frail Elderly too? Kerrie stated, I don't know if I can tell you what the appeals were about without having to go through every single one and making a note because we don't log it that way. I may be able to, let me look and see because I can also pull appeals with the other issue next to it. So I can pull I/DD appeals and what the thing is next to it. It possibly could be a long list but I could possibly do that. The participant then asked about the reduction of services for HCBS I see that you have 15, is that 15 separate individuals that have reduced services? Kerrie stated, it is 15 cases; probably separate but sometimes there might be an overlap. Eric asked, unfortunately I don't actually have the documents in front of me at this time but I'm curious Kerrie you gave numbers of contacts for the various MCO's I think it was 5, 31, and something. What is the distribution of members with the different MCO's? Are those numbers proportional? Russell stated, we will be talking about the MCO memberships when we dig into the KanCare Executive Summary. Eric are you receiving my emails? Eric stated, yes, I am just not able to get to it this morning. Russell stated, we can do Kerrie is pop back to this topic once we get there. Kerrie asked, can we give you the number when we get to the KanCare Executive Summary? Eric stated, sure. A participant asked, Kerri did you say that under the issues category that under the issues category there are 46 grievance and appeals and one grievance? Kerrie stated, there was only 1 grievance. Participant asked, of all of the appeals that were made how many were actually overturned? I did not see a definitive for I/DD so I was just curious? Kerrie stated, I don't have that information. Another asked, those are not necessarily appeals filed for just questions how to do it? Kerrie stated, I don't know how many follow through to do it or not. Participant stated, so these are just questions on how to do it. Kerrie stated, sometimes how sometimes they are calling me back. I get a lot more

calls that what are listed there because I don't log every single call because if someone calls me five times about their appeal I am logging it on the same person. So, this is probably understating how many calls I get. Participant stated, right but it is kind of an unduplicated, if you have one person calling it is logged in one time regardless of how many calls you get from that person. Kerrie stated, so I close the case and if they call again on some new topic then I open a new one with that topic. Russell stated, we will cover appeals and grievances on the last page of that document too. Liz Long stated, we have a report that we collect a lot of this information. You will see that on the last page of the Executive Summary we have a high level summary. If folks have specific questions such as how many I/DD folks or that type of thing we do track by waiver members the appeals. So I can probably pull some of that data for you by the end of next week. Kerrie stated, that is only by MCO not by State Fair Hearing. Liz Long stated, we have State Fair Hearing as well. Take a look at that page when we get there and see if folks still have questions. Aldona asked, is the grievance the next step after the appeal is made? Kerrie stated, no a grievance is something completely different. A grievance is like a formal complaint and it is usually when it is something you cannot file an appeal for. For example, someone was rude to you or you're not happy with how something was handled. You can call and say my Care Coordinator is not handling my case well or that kind of thing. Or like with Transportation if things were handled improperly you can't appeal Transportation. There is no way to appeal transportation so you would have to file a grievance about transportation. That is one issue that is out there about transportation. It is the first level but the other part about grievances is sometimes something I tell people because they do not believe it matters if they file a grievance is that it does matter because CMS keeps track of grievances that are filed against the MCOs. They keep track of the number, how quickly they response, and so it does make a difference. There was one lady that said for Hispanic speaking people were not being listened to our handled well. I said, then you need to tell all of your Hispanic friends to be making grievances about that because CMS keeps track of that and for every time they file a grievance about it's noted. Grievances do have a degree of power in that they are noted and tracking mechanism there. Numbers make a difference so if you not liking what is happening then you need to make your voice heard. Aldona asked, are you the first point of contact when filing a grievance? Kerrie stated, no, you just call the customer service line and say you want to file a grievance. Russell stated, people can file a grievance at the KanCare Clearinghouse in Topeka or with their local DCF. Probably with whoever you have the grievance with there are different avenues. Kerrie stated, if you have an issue with your managed care organization that is who I am talking about that's who when it comes to CMS keeping track and documenting you call the customer service line and tell them you want to file a grievance. That is what I was referring to as CMS keeping track of that. Russell stated, when I said the grievance is the first level I don't want people to think you have to file a grievance before you file an appeal or Fair Hearing. You can start as an appeal you don't have to start as a grievance. Barb Conant asked, is an appeal done with an action has been taken against your case or services. A grievance is when you're unhappy with the service you have received. Such as someone has been rude or someone hasn't shown up. You have to get a notice of action that an action has been taken against or case or a reduction of services for an appeal. A participant asked, are they reporting if they receive a grievance against one of their providers? So say a transportation provider doesn't show up, they file a grievance with the MCO? Kerrie stated, yes. Participant noted: I had a problem with medical transportation that they did not call me until that morning telling me they could not get me to an appointment. Kerrie stated, you can file a grievance about that. Participant asked who would I file it with? Kerrie stated, you would call United customer service to file a grievance. A participant asked: 'so any part of the delivery systems shows up here right?' Kerrie stated, yes. Russell stated, in the enrollment packet that I went over there is the enrollment booklet on page 6 and 7 there is some information on grievances, appeals, and State Fair Hearings. Kerrie stated, on page 3 at the bottom of the page we talk a little bit about the comparison between that last three quarters and they have stayed pretty consistent pertaining to the top three categories. Durable medical equipment, billing, and appeals and grievances have been in the top six. So that has been somewhat consistent. If you go to page 4 these are two charts that are new. One is waiver related which is on the right hand side. They are not all waivers but they are categories that we are now keeping track of. The top ones are home and community based waivers but we also are keeping track of money follows a person, behavioral health, and nursing facility calls. That is how I will pull out I/DD and waiver information that some of you were requesting. The resource category is what we keep track of when we are

resolving a case. Where it is we are referring people too or what kind of information we are using to help people. A lot of what we do is help people resolve their issues. It is referring people to another agency or another organization to help them resolve their case. What I am keeping track of is where we are sending people to in this and rather it was resolved or not. A question was asked, how do you define resolved? Kerrie stated, we call them and ask them if it got resolved. Usually it is resolved when I talk to them. You can see by our conversation, I talk to them and say it looks like I am going to hand this off if you have more problems you need to call me back. I consider us done when I have that conversation and tell them they need to call me back if they have more issues. But, I leave the door open and let them know they can call me back if they need too. I am only one person, I have another person that I have hired but she needs to be focused on getting a program up and going. She helps me occasionally when I am out of the office but for the most part I am still just one person. Even with appeals we may have a 15 to 45 minute conversation when I have an appeal case so I can help them to the fullest extent that I can. Sometimes we have several conversations because it is a more in-depth case and they call me back which is ok. I talk to them and I know we are going to have that kind of situation. But, most appeal cases we have a long conversation then, I am going to send you this information, and then if you need more help you need to call me back. Then I close the case. That is why you show that over half of the cases I have in a quarter are done after one or less. Many of the cases what happens is I send an email a lot of times to the MCO or someone else and ask them to follow-up. I expect them to follow-up and take care of it. Then what happens is the assistant that I have will follow-up maybe a month later and say did this get resolved. If it didn't she will check to see if we got an email back, she will call them to make sure something happened, and then close it. We are checking back to make sure that something happened. If it didn't then it comes back to me and we start over. That is why sometimes that number is longer than a week or two week average is because it is not immediate. Russell stated, back here on page 2 it says that you provide testimony to the Bob Bethel KanCare Oversight Committee. Would this be the same material that you are providing here today that you provide them? Kerrie stated, this is the exact report that I turned into the Oversight Committee.

In response to questions noted by Kerrie, she sent an e-mail to Russell with this information:

- **From:** Kerrie Bacon [mailto:kerrie.bacon@kdads.ks.gov]
  Sent: Friday, December 19, 2014 10:12 AM
  To: Russell Nittler
  Subject: CSI Meeting information
- Russell,

- Here is the information in response to the questions that came up in the CSI meeting yesterday. This information is taken from 3rd Quarter, 2014.

1. How many Appeals by waiver? FE – 3; I/DD – 4; TA – 1. Balance not identified.
2. What were the I/DD topics for appeal? Reduction in hours, loss of therapy and prescription; balance not identified.
3. For HCBS Reduction in hours of service, how many were I/DD? One.
4. What were the Reduction in hours of service by MCO? Amerigroup – 2; Sunflower – 7; United – 3; balance not identified.

Those were the questions I had noted. I hope this is helpful information to those with questions.

Sincerely,

Kerrie
Kerrie Bacon
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KanCare Executive Summary – Charts and Graphs

Liz Long, KDHE

We will walk through this page by page and if folks have questions about the data on that we can stop and ask that question. This was most recently presented to the Legislatures last month and the Advisory Committee just this week. They had some questions as well and I will answer those as I know them. I think early on in our call we had the Medicaid eligibility and expenditure question about how many of the folks are with what programs, so that is the first page. The second graph to the right is the expenses for the individuals and should look very familiar. There is always the conversation about the cost, children are not as expensive typically. You can see that illustrated here. The second page payments by the populations and the members. So we break out and we talked about this at your last meeting about the different populations and why we break them out that way. It is represented by MCOs so if you want to see for example, Sunflower stands out in the DD world that they have a higher population and the cost is relative there. The specific question was people with each MCO so if you look at page 3 the 2nd pie chart that count is by MCO and it breaks out pretty evenly with two at 32% and one at 36%. The provider network has been updated and I/DD providers are updated as well. Just one thing about the percentages, we will probably not reach 100%. Please be aware of that, there will be providers that do not want to contract. The fourth page is denied claims, when we look at this and I have added some data so you can see where the denied claims percentages are from 3rd quarter of 2013 to the 3rd quarter of this year you will see that they are tracking pretty similarly. Overall we have by provider type you can see their percentages if you are interested in more detail there. The value added services are listed and are slightly updated. They aren't changing a lot pertaining to which ones are being utilized. The top three have stayed consistent in dental, member incentive programs, and vision. United it was vision and it has been very strong with that. The 2 pregnancy programs are very highly used. The next page is a summary of in-lieu of services and that is an additional benefit that the MCOs provide to track the utilization. Some of these things are existing Medicaid services that are not covered by our State plan but the MCOs are allowed to provide those after they have gone through the medical review process to see if the person has a medical necessity. There are non-covered services that might be beneficial to the person and again that goes through their committee to see if that will be allowed. The biggest example of this that we see is utilization of sleep studies not being something that is Medicaid covered but knowing that someone has sleep apnea can benefit their overall health so it frequently gets covered. Russell stated, just for a high level when we think in-lieu of services by the MCOs these are things that Medicaid doesn't pay for that is not included in their value added services but the MCOs are going ahead and providing these services because they think it is going to pay off in the long run? Liz stated, yes, theoretically the MCOs believe it will improve the persons health and reduce the MCOs expenses long term. Although, I have seen several cases where something is provided that really is just a benefit for the person. The two sections are just really about things that are traditionally Medicaid services Kansas just hasn't added in their state plan. That might be adult briefs, or additional catheters, or those types of things. Some are additional waiver services, I see a lot of in home services in-lieu of nursing facility placement. You may also qualify for a different waiver service in addition to. Non covered things, such as someone with asthma would really benefit from an air conditioner in the summer in a particular part of the state so they can pay for an air conditioner. It is not something that Medicaid would ever cover, it is not something that we would typically pay for as a medical program but they see it as a benefit to the family to do that. Russell asked, the MCO is not reimbursed for this? Liz stated, the non-covered services would not be something they would ever be reimbursed for because it is not a Medicaid service. The additional Medicaid covered, that is not something that we would typically have included in our state plan we will look at the utilization cost of that, look at their rates for next year. It is not a one-on-one this is just one of the considerations that we will look at. The last page is member grievances and

appeals. We had a lot of discussion earlier about that and I just want to start off with a couple of things that believe was covered but I will reiterate so everyone on the line knows. Consumers can go straight to appeals or straight to Fair Hearings without filing a grievance. Or they can file an appeal, grievance, and Fair Hearing all in the same day for the same issue. That could inflate our numbers so when you are looking at our data keep that in mind. There is no order of you have to follow. You choose where you want to go and can file these directly with your MCO. Russell stated, the last time we talked about appeals is where we started seeing the durable medical equipment so I have asked Kelley Melton who is KDHE's Pharmacist to talk about why do we have so many appeals on durable medical equipment. Kelley Melton stated, a lot of different things fall under durable medical equipment. Specific to what I do we have had a lot of problems with test strips at the pharmacy level. In quarter 3 you are going to see a lot of appeals for that. We actually made a change starting October 1st to try and make test strips more accessible at the pharmacy. Where if the member is willing to use their plans preferred test strip brand they can get it at any pharmacy that contracts with their plan. If they want to stick with their regular brand they will have to continue going to a pharmacy that has the capability of being able to bill for DME claims. Some other things that fall under DME that we have had to work through with KanCare are wheelchair claims that we have seen a lot of patients struggle with. There are other things such as catheters, nebulizers, and those types of supplies are under durable medical equipment. If you have something that does enteral nutrition and have some type of feeding tube and have to do some type of TPN that is under DME. There have been a few high level things such as the test strips and wheelchairs. But, in general DME is difficult because there are a lot of different things that fall under that area of billing. Aldona stated, at the last meeting I did bring up the wheelchair durable medical equipment denials. They will approve some parts, for example, one lady told me they approved for parts but did not approve the tires for the wheelchair. The other thing is I was talking to a nurse yesterday and she told me that when she made a home visit the man was denied a walker. He literally could not walk by himself, she had to help move him from place to place in his own home. I have a hard time understanding why a walker would be denied. Kelley stated, I think we would have to know more specifics about the case. Katie stated, there are times that requests are denied because not all of the information was provided. The appeal rights are included in the letter and it states if you have more information or you would like to appeal this decision this is the process. Russell asked, Katie can you give us an example of someone who needs a walker what type of information would they need to provide the MCO? Katie stated, it would be an order from a physician and usually something like an H&P that states this member had a recent injury like they just broke their leg recently or something just detailing the condition and describing the need. All requests for DME over a certain amount are checked through a system that you must meet certain criteria to receive the equipment. If it is not documented correctly or if the documentation is not provided then usually we reach out to the provider and request information but if we still cannot obtain the information needed then it will go through a denial process. But, there is the ability for the appeal. Liz stated, there a couple of other things that I would like to add one is that not only is CMS looking at our grievances, appeals, and State Fair Hearing data but KDHE and KDADS reviews that report that we get as well. We get that quarterly and we get it by each MCO; by member every grievance, appeal, and State Fair Hearing that have been submitted. What you see here on the last page is the executive summary is a compilation of that. Someone asked about the reversals or overturns that is listed here for State Fair Hearings. Where if that has happened in the member saver or provider saver. I am able to track by waiver the members, I do have some rough numbers along those lines that I would be will to include in the minutes that come out for your next meeting the ones for last quarter for example. If that is interesting to folks we can share that. We collect a lot of data, we do this as a summary so if folks want to know more detail behind a summary I can provide that if you ask some more specific questions. Russell stated, we followed up from last quarters meeting with an email the broke out Amerigroup's, Sunflower, and

United's waiver population. Did you have any comments on that? I believe that was a request from someone. Liz stated, nobody followed up with me about that. Russell stated, I believe you sent an email to me and I forwarded it out to everybody. Basically, it is just breaking down the number of members each MCO has per waiver. A participant asked, when we are looking at the appeals again I am looking at the number of appeals reversed in the providers favor for each one of the MCOs and it seems that it is in favor of the provider more than it is in favor of the member. I don't know if that is because it was just so cut and dry and I am interested in this because I am finding some of our services are being cut by the MCOs for our individuals and we are going to be in an appeal process with them real soon with one of my individuals. So can you kind of tell me what the rationale is behind having the providers getting the in favor of the appeals? Liz stated, I would not be able to tell you because I don't look at the actual reason for the member appealing versus the provider and the decision. But, we do have staff Dorothy Noblit and Roxana Alexander who both look at the report at KDHE and go through that type of things looking for trends to see if there are issues where that has happened for some sort of reason. If there is a pattern to those decisions if that makes sense. The participant stated, yes it does. Liz stated, they look at this and they approve that data back to me every quarter. They look at it from the per member level. It also goes to staff from KDADS and I'm sure that they review it as well. There are multiple sets of eyes looking into that process and also this is a topic we look at when we go onsite every year to do oversight monitoring for each of the MCOs. We pull cases and walk through the documentation step by step. There is a State Fair Hearing process that you have an outside party looking at this decision. Marilyn stated, right here where it talks about number of health care plan appeals reversed in providers favor, members favor, and here is the State Fair Hearings and how many were overturned. Joe asked, this is by MCO? Are you looking at the State Fair Hearing column and saying why it is so high for this group and this group is so different? These would be how you are comparing each MCO by each MCO. The other issue is we are looking at the appeals compared to State Fair Hearings. Marilyn stated, let's just take Amerigroup, the number of health plan appeals reversed in the members favor is 9, the number of appeals reversed in the provider favor was 95. Joe stated, those are State Fair Hearings. This is still high. Marilyn stated, that is what I am trying to figure out and if we go one step further to the State to appeal it does not look like our chances are very good that it is going to get overturned. So, that is my question. Another participant stated, where I think it would be helpful is where we break out grievances and appeals because they really are not the same thing; they get kind of lumped together. Liz stated, it is broken out. The participant stated, ok instead of talking about them in a lump it says number of grievances and appeals. Liz stated, some of this data will have more by next quarter because I asked for some information adjustments to this report. About every quarter we get a little bit less or a little bit more. Joe stated, another question Liz is in the State Fair Hearing columns do we know how many of the 99 we have 95 that are provider and 4 that were in favor of the member. Do we know how much of the 99 were providers versus members? Liz asked, as far as the submitted appeal? Joe stated, yes. Liz stated, these are all State Fair Hearings submitted by members. I have a completely separate report that pertains to just providers but they don't get grievances. Kelley stated, just to clarify when it says provider favor on these tables that means the MCO? Liz stated, I believe it is one in the same in this example. At the State Fair Hearing level a lot of the members are getting assistance such the provider is helping appeal. Joe stated, would it be interesting for us to have some talk to us about the State Fair Hearing process and what they look at. Liz stated, I am sure that KDADS attorney's just provided training out there that we can probably find between Dorothy Noblit and maybe we can get one of the KDADS attorney's come to your group and talk about what the process looks like and what are some of the trends they see happening. I believe that would be an appropriate agenda item for you next time Russell. Russell stated, I am putting it down. Aldona asked, I need to get back with the nurse and I want to make sure that I tell her the right thing to do for the young man that was denied the walker. I need to tell her he needs to go through the appeal

process first and then get an order from the physician? Kerrie stated, have her call me at 855-643-8180. Joe stated, the representative for United how I heard it was they do not have to go to an appeal if there is more information correct? So, if they go and get a physician order they can submit that and bypass the whole process. Kerrie stated, I will discuss that with her. James stated, one other resource the local centers for independent livings have a surplus of walkers available. They bought more walkers through Medicaid than the State could ever use. Aldona asked, are you talking the about independent resource center? Kerrie stated, I will give you that information too.

Mental Health-Phyc Units and Waiver Updates:

Greg Wintle, KDADS

We are currently in the process of working on renewals for four waivers; Frail Elderly, Physical Disability, I/DD, and the Traumatic Brain Injury waivers. As part of that renewal process we had 3 days of in person meetings in Wichita, Hays, and Lawrence in the month of November. We followed those up with a couple of conference calls on November 17th and December 4th for folks. Since the public meeting we had November 12, 13, 14 we had been in a public comment period for the waiver changes. The important thing that needs to be the focus is that on our KDADS website is a summary of all the proposed changes for the waiver programs. These have been posted and we have been taking public comment for a little over a month. The public comment period is coming to a close this weekend on December 20th so want to encourage folks if they want to go out to our website there is a link to a survey where they can still submit comments about the potential waiver changes. To get that information it is on the website also. There is a rather lengthy document that does an overview of proposed changes that are consistent across multiple waivers. For example, one change is that we are the name of personal services to one name for all waivers to drive some consistency. For example, on the DD waiver we called it personal assistant services; the common name across waivers now that we are proposing is personal care services. That is a rather lengthy document and talks about a lot of different things. In addition to that there are also documents on the website specific to proposed changes for each of the four waiver programs. Also, there is a summary of changes since our initial HCBS transitions were developed back in May and June that have had some updates made to them such as some timelines, milestone targeted dates to complete portions of the transition plan for each waiver. Posted on the website are the current drafts of the waivers that includes the draft proposed renewal and transition plan information. We have had about 90 comments made through the website aside from the public comments collected through the in person meetings and conference calls. We will review that feedback and consider what changes to make; then we will make our changes to our waivers, and then we will make our submission to CMS for our waiver renewals for those programs. There is a lot of information that folks can get at http://kdads.ks.gov. There is a public notice that changes for public comment, all of the documents specific to each waiver, the survey, and the draft of the waivers themselves are posted on the front page of the website. A participant asked, what is the projected date for submitting to CMS? Greg stated, we are on a timeline at least on the DD we have to do it before the end of the year. I believe the timeline is the same for all of them but DD is a little different because we had a renewal date of July 1 but the timing was rather awkward with submitting the transition plan information. A lot of that was just coming out at that time so CMS has worked with us, we have done a couple of extensions to allow us to put some more detailed information into the transition plan. Aldona asked a question pertaining to I/DD Health Homes if someone no longer has a case manager because they were automatically enrolled in Health Homes who does the PCSP for the person served? Is that written into the bylaws of the Health Homes or plan somewhere? Russell stated, it is my understanding that they should not be losing their targeted case manager because they were assigned to a Health Home. The Health Home is with that person. Aldona stated, if the case management doesn't contract with the Health Homes then they do lose them. Greg stated,

they lose that specific entity if they don't contract with them. They do not lose the service. Aldona stated, for example, if my son was automatically enrolled in a Health Home. In my case I would lose his case manager because they are not contracting with the Health Home. Greg stated, it sounds like they might have made a business decision not to provide case management for a person who is in Health Homes. That does not preclude them from choosing someone else who is choosing to participate in case management. Aldona stated, this is confusing to me as a parent guardian because I was told there are basically some people that are not choosing to contract with the Health Home. Say for example, they have had this case manager like we have had him for a number of years. It is just a case management group that we contract with then they would lose if they are included in the Health Homes if we did not opt-out then we would lose the case manager. My question is if that happens to some people is there anything written about how does the PCSP for the person? Russell stated, it would be the next case manager that was assigned with your Health Home. Aldona asked, so the Health Home they were assigned to would be the care coordinator or another case manager? Russell stated, another case manager that would be assigned to your son's case who is contracting with that Health Home would be the person that would write it.

Osawatomie:

Marilyn Kubler

I am hoping that there will be someone on the line that can give me some clarification on what is happening. In our situation and not just mine we have had some very tragic outcomes with not being able to get our individuals placed at either Osawatomie or KU. We called 35 different hospitals last week to get this person placed in a psychiatric unit and no one would take her. The reason they stated they would not take her was because she had a MR diagnosis. Is there anyone that is understanding what is going on with this situation or what we are going to do? What is going to happen is people are going to end up in jail because we have called the police several times on these people that we are talking about right now and that seems to be the only thing that is left at this point. I would appreciate it if someone from the State or someone else could tell us what our options are out there. Ted Jester stated, I can speak a little bit about Osawatomie and some things that are going on. You mentioned that he/she has an MR diagnosis or an I/DD diagnosis. I will say by Statute I believe this KSA 59.29.46 there are four or five diagnosis that by Statute are inappropriate admissions to State psychiatric hospitals and that would be one of them. The others would be if their primary diagnosis was substance abuse or chemical dependency, if they had organic brain syndrome, or organic personality disorders. All of those are by law illegal to place in a State psychiatric hospital. That is why that person would not be admitted to Osawatomie or Larned State hospital. Marilyn asked, so what happens to them? What can we do about it? Ted asked, Greg are you still on the line? I guess this would be a Parsons placement. Marilyn stated, Parsons would not take her. Ted stated, that is set up for those individuals but I don't know the protocols and how to get access into those hospitals. I only deal with the mental health hospitals. Eric asked, is it true that the person has a dual diagnosis? Marilyn stated, yes, she has two. Eric asked, is one considered primary over the other? Marilyn, yes MR is. A participant stated, I used to work at a CMHC who did the screenings a member or client who presents, the driver about why you would get admitted is not whether they are MR or not but, is the driver for their symptoms psychiatric in nature meaning they are suicidal or risk to others. Just because someone may have symptoms of mental health does not necessarily mean they can be admitted. Some of it has to do with who is there guardian too. For example, someone presents and they are not at immanent risk for self or others and they don't want to go into the hospital then the person who is doing the screen has to make a decision about whether or not if they can involuntarily commit which is a whole different level of criteria. Marilyn stated, in this case she asked to be admitted. Barb stated, then it would come down to the symptoms and whether or not they met the criteria for a hospital versus they have psychiatric symptoms but they don't meet the criteria for the hospital. Sometimes it is about how

information is being reported and is the person who is doing the screen have full information? The screener should be trying to get some other information from other people who know what is going on with that person. But, sometimes they have what they have. I don't know about this case in specific but sometimes that is what drives an admission or non-admission. Marilyn stated, we went through the CMHC in Johnson County and they said Rainbow should take her but they wouldn't take her. They said they were full but they weren't full. They are supposed to have emergency bedding but they didn't have it or they said they didn't have it. Katie stated, if you take someone into an emergency room they cannot deny them care. But, if you call ahead and ask if they would like to accept them they can say no we can't take this person. If you take them to an emergency room to a facility that has Psyc services they cannot deny them care. Marilyn stated, but they did unfortunately. We did that, we went to the emergency room and we were denied at KU and Shawnee Mission. Katie stated, that needs to be reported because that is against the law. Marilyn stated, ok, we will report it. Joe Ewert stated, KDHE is the entity that does the inspections. Aldona asked, Marilyn did you state that you called Parsons state hospital? Marilyn stated, yes, actually Parsons has been working with this individual for some time and they wouldn't take her either. Aldona asked, why wouldn't they take her? Is it because they are full, I know they have a waiting list? Marilyn stated, probably. Greg asked, was the CDDO involved in putting together a gatekeeping request? Marilyn stated, we contacted the CDDO but I don't know what influence or what they did. Greg stated, it is not influence but the procedures we have in place requesting admission to an ICF. On the DD side that begins with a packet of information completed with the request for admission to the ICF. Our office oversees the ICF program. It may be better to take off of this call and discuss and get Ashley involved. Marilyn stated, ok. Joe stated, as for the hospital complaint the number is 1-800-842-0078.

Case Managers Continuity

Russell stated, I believe we are going to hear from our MCOs about what they are trying to do to keep this process and keep case managers. Janice asked, I guess there was a question about case manager turnover? Ed stated, I went out to Garden City to visit some relatives and several of the people that I talked to started to tell me about some challenges they were having with KanCare. I asked them what MCO they were with. They felt with case management the follow through was not there. We have had the same issue, my kids are on the TA waiver the case manager just put it in the next ones lap and she said we are going to keep up with you. Someone in Wichita that I talked to are having challenges and someone in Overland Park told me the same thing with all three of them. My question is there one process in place if you decide to move to greener pasture and someone moves into your place is there continuity? Janice stated, we look at if we have high turnover which we do not believe our turnover is necessarily high but that is one of the things that we are taking a look at. If you have somebody for example who leaves immediately you can't do transition because they are gone and for example we have people who are on FMLA so something happened where they had to leave abruptly because they have a medical condition. We do have a fair amount of people who are on FMLA. So part of what we can do it fill that cap when we can because we don't get a warning or we don't have a way to do a transition the way you would if someone quits and give you two or three weeks notice and you can do some transition in that period. One of the things we are taking a look at is are we doing a good job when we have that opportunity to do good transition and at least explain to the member why we can't. Unless I have examples I don't know in this case if this would have been why but it is a fair question. Sometimes you transition because a case load is too high because some areas may have high volume so that person has more than they can fairly manage so we transition it to someone new that we bring in. Those are opportunities that we should do good transition on. That is something that we are looking at, when we have to make a change directed by us the member knows and the two meet together for the transition. But, it depends on why somebody leaves that makes it

either harder or easier to do some of those transitions. Ed asked, is there a specific continuity plan for the case managers? When I/DD just rolled over there is a lot more in gross or a lot more care for them. A lot of them I think were overwhelmed with the responsibilities and things like that the way I understand it and I don't know the specifics of each one of the cases; I usually get just the brief recap. I ask what have you done about it and they say nothing. I realized through talking with several people that there is an issue and I think it should be brought up. Janice stated, one of the things I can do is follow-up with each of the managers in the different areas. I believe this would be a logical thing if for some reason there is quick turnover, not an ability to transition that they can at least outreach to the member to say here is what is happening or case manager for whatever reason is gone I will be your contact person and as soon as we get someone assigned to you we will notify you so they can outreach to you. I think that is a simple thing that we can do that will really at least not have that member feel they are sort of out there. They will always have coverage and have someone that can respond to their needs but that doesn't mean that we have communicated that well. That is something that we can add to our process so we do appreciate that feedback because if we are not doing that then we need to. Ed stated, at one of the meetings that I went to they were talking about one child who was in one hundred and some foster care workers before he turned 18. It is like oh my goodness, someone should be fired. Janice stated, that is different because that is a whole different system. Ed stated, I know, but if someone feels overwhelmed or whatever also in the case manager they get one and then all of a sudden they are gone and then they get another and another one. Marilyn asked, you are talking about care coordinators not necessarily case managers? Janice stated, right. We do not call them case managers we call them case coordinators. Njeri stated, as a consumer, I had this experience this year. I was transferred as an individual to three different people within three weeks so I think that is a lot personally. My concern is not only the continuity but also like you said every MCO has a plan for the consumer and express what that plan is just like all of this other just. This way we know, I think we can have more information about what is going to happen if there is a transition in staffing. I don't care what the reason is necessarily but I need to know what is going to happen with me if anything happens to the person who is responsible for me in that system because it is a system. I am not necessarily individualized in that system but there should be a system in place that someone knows what happens if someone just doesn't come to work that day. Aldona stated, I totally agree with that because we have had that experience in the I/DD system with our MCO as far as care coordinators go our son has been assigned three care coordinators. The second one I didn't even know about until the third one called to let me know. There was some concern from the third care coordinator that was assigned that our son would be taken off her case load. I requested to keep her as the care coordinator because one I believe she is well qualified because she knows about behaviors which was very important to me plus she reach out to us. She is with Sunflower and came to visit our son and looked at his house to see all of things we have in place to help keep him healthy and safe. As a parent guardian I believe it is important that we can request to keep someone if we want them. Njeria asked, are you saying that should be a part of what I am saying this paper or system is so that we can review whatever the MCOs come up with in their systems so we have input about whatever their ideas are about what needs to happen when something happens to their staffing pattern that impacts us as consumers. Aldona stated, yes. Njeria stated she would like to put all three of those on the table then. Russell stated, lets hear from Sunflower. Mitzi do you have anything to add here? Mitzi stated, I am unclear as to what the question is. Russell stated, I think the issue is about the high turnover of care coordinators with the MCOs or targeted case managers at a different level. What can the MCO do about it and what are their plans are. When people get sick and leave they get sick and leave but do you have an apparatus to let consumers know that they have a new care coordinator. Joe stated, I believe it is a little bit more than just notification too. Part is knowing in front of the situation how that is going to be handled within the system. Mitzi stated, currently our care

coordination team has a buddy system so corresponding care coordinators have a buddy that covers their case load in their absence. So in a case where the case coordinator was to leave that buddy would take over that case load until a new person is hired. The only method we have of informing members about that is reaching out to them. We give them introductory phone calls. We don't necessarily have a letter that we send out; I don't know if a phone call or a letter would be more preferred. I am open to suggestions because we do realize there is going to be turnover and if we hear that member's want a letter or some type of system in place we will research alternatives but right now we just reach out to the member directly. Some of the confusion may be that when a temporary care coordinator contacts the member letting introducing themselves sometimes members feel that they have gone through three care coordinators once a new one is hired. Njeri stated they really have been through three workers because that temporary person is a worker; they are there and then their gone. Joe stated, it could be useful as a consumer to note that that temporary person is there before their primary is gone. Katie with United stated, I believe that all MCOs have a common goal of providing as much consistency as we can and as much communication and transparency with the member as we possibly can. So if we know in advance that someone was going on FMLA or some planned event we would of course communicate ahead of time who is going to covering during their absence. Members can also always call the 800 number on the back of their card if they can't reach their care manager. For example, they are expecting a visit and no one comes they can always call the 800 number and be connected with the team that supports the care coordinator and then yes if we do have to assign someone on a temporary basis we would reach out and speak with each member. Let them know what the situation is and what they can expect to help calm any fears or anxieties. A participant stated, but people find out too late. I found out when I found out that my care coordinator quit while I was in the hospital and no one contacted me. A participant stated, this would be kind of covering that communication. A participant stated, I know that it is communication but if you are in the hospital and you try and call me at home that doesn't work. Katie stated, I believe what you say is good feedback back to our systems because sometimes it is having part of those formal communications. I don't believe that is unreasonable to say lets get something and make sure there is good communication because we can't always predict what happens. A participant stated, this person was here and knew I was going into the hospital and knew what was going on, that is all I am saying and someone to talk to before I went into the hospital. Joe stated, I believe that would be the specific ask that we would meet from each plan internally and come back to have something to describe with us. Mitzi stated, I appreciate the request to come back because I believe how we heard the question was do we have high turnover? That is a relative term. Our perception was how is your turnover which is a different question than what do you do when there is turnover. I believe that the feedback on how we can formalize that communication so that at the very beginning engaging with the member her is what will happen if there is transition. I believe that is a fair question and that is good feedback. Aldona stated, I appreciate the MCOs listening to this because I would have as a parent guardian appreciated a letter in the mail stating that my second care coordinator was no longer going to serving my son but here is your contact and phone number that is now assigned to your son. I always keep that to reference for my son. Mitzi stated, I like that idea because that is happening when it happens. Aldona stated, and I would have that for my records. Katie stated, I am not wanting to be argumentative but I am trying to think how we can cover the needs operationally in a consistent manner and what I am thinking is there are so many daily changes and there are so many members to take care of I feel that if we send out 5,000 letters saying for example, you have Kara as your care coordinator and if she is sick you can call Elizabeth as backup that is fine and would be easy to do. But then if Elizabeth goes out on leave it would be really hard to remember certain people have Elizabeth as a backup so now we need to send out a letter stating Elizabeth is out on leave so she can't be the backup. This would be very complex. I am wondering if we could just have steps to do if you can't reach your care coordinator just in general.

Just saying something like there is always going to be someone who can help you but in general if you can't reach your care coordinator that is what you should do. This could be just calling the main number and asking for assistance. Does that serve the purpose? The manager will always be there rather than being very specific. Joe stated, I believe I understand the challenge; specifically some of the pieces that stand out to me that could be done is just the process. So welcome to United here is your care coordinator, your care coordinator may get promoted/sick if this happens we are going to provide you a new one. This is how we are going to tell you about it. Here is where you need to call if you need something in between that time. It is really just education at that point and then internally having your care coordinators provide that dialog on the ground is important. I think today what we are asking for is that you take this back to your teams and that you discuss it in-depth and come back to use next quarter and describe what your conversations looked like. Mitzi stated, I believe that is why the question came up is what is your turnover because there is an average turnover rate in the United States for positions. If your turnover rate is 20% that is high, if your turnover rate is 10% that's ok, so what is the turnover rate for case managers for you guys. Katie stated, for us our turnover rate was about 15% but that is not going to get at if you have someone who leaves right away because of FMLA because they are still employed by you it is not turnover. So I believe that is the other piece we are looking at. I don't believe our turnover rate was really getting at what you were saying because what we do have is we have several people on FMLA which impacts what you feel like is turnover because all of a sudden your persons not there anymore. I want to make sure we are not short sided on our end. We do look at turnover because it is high cost because you have agency overtime when you have turnover. But, that is not the same thing as too what you said how do we communicate that no matter why that person is gone. How do we make sure the member doesn't feel disconnected or not sure of what their steps are so we did look at our turnover. Joe stated, we appreciate the plans looking at this during the next quarter. Marilyn asked, we heard turnover rate from one did the other two look at their turnover rates? Katie at United stated, our's was 6% for the last year. Misty (Sunflower) stated, I don't have that number but I would be happy to share that number with the group once received. Russell stated, we think it was 6% for United. Janice, we did it overall which our turnover overall was 15%. We can break it down for LTSS turnover and come back with that. Marilyn asked, United is that 6% just care coordinators? Katie stated, yes it is. That information is tracked in our LTSS report. Janice stated, that is true. Our LTSS Oversight has that information that the State gets monthly from each of the MCOs. Aldona stated, on a positive note I wanted to say that we are very happy with the care coordinator from Sunflower. That is why as a parent guardian that I requested to keep her. I just wondered if they don't move up or out of the company is that something that the MCO consider looking into for parent guardian requests for someone that they are comfortable with? Janice stated, absolutely. Mitzi stated, we try not to transition care coordinator unless someone is new or if there is a very good reason. But, I know Sunflower just went through a large reorganization of their department. There was a little movement just to better align resources.

Public Notice of Meetings and Deadlines:

Barb Conant

The way I understand it when you were preparing for the public meetings in November there were emails sent out to everyone that they had an email address for but from looking at it closer that is members only. My request would be a consideration of a process to alert others such as stakeholders and advocate groups. Apparently, there is no process in place to notify us. A number of us are on the Health Homes mailing list, this mailing list, and others. I would be helpful to have an email notification when those public meetings are going to occur and there was one planned for last Friday that I believe postcards were sent out for. There's one tomorrow that was just posted on the

website. There a little bit of an inconsistency, I would request you would put something in place to let all of us know. Russell stated, I believe KDADS response to this when I brought this up was they do try and post things to the home page on the KDADS website. There is the KanCare website that when things are added to the KanCare website there is that little tickler up there. Barb stated, Right, that is how I learned about the meeting tomorrow but since they don't hook back to each other you have to look both places. Like this meeting, it is a public meeting but not necessarily a notice to the public but I'm just thinking that it isn't expensive to send out emails and when you have a public meeting you have our email addresses anyway so if those could be entered in and noticed. Russell stated, I believe that each KDADS waiver has a serve list and we can put your name on those. I think they wanted me to give you a heads up that you may be asking for a lot of emails. Barb stated, yes, and I don't need to be on the FE list serve I would just like to be noticed (I believe all of the advocates would like to be) because you rely on the grapevine and if something is cancelled and we didn't get a postcard for the last one. I think it would be helpful. You have our contact information already. Kerrie stated, I believe that KDADS is saying the best way to receive these emails is to sign up for the I/DD waiver list serve. Barb stated, I did not get that email all I got was to check the website. Russell stated, we would have to put them on the list serve. Kerrie asked, are you connected to a waiver? Barb stated, I'm not a service provider, I'm not a KanCare member, I'm an advocate organization. So, I fall between all of them. Kerrie stated, the other place but not always that they tend to is the KCDC disability news. Barb stated, my concern is we are asked as member organizations to get the word out that there are these meetings but there is no way to let us know to carry that message. Marilyn stated, that is one of the things that we have noticed in the I/DD community is the lack of coordination between the State and the CDDO's. It used to be that we received all of our information from the CDDO's but now it is coming from every which person. We sometimes get it and sometimes we don't. There is a lot of disconnect in communication. Russell stated, I believe that KDADS really wants to rely on that website. What I believe you are thinking is do I need to visit your website every day. Russell stated, KDADs also posts them to their Facebook pages. Russell stated, we will take this back and discuss it with our Director of Communications.

Future Meeting:

Russell stated, next time I believe we will spend more time talking about appeals and Fair hearings. Ask the MCOs what their communication of transitions on new case managers might be. I normally wait to set our meeting until after the Advisory Committee meeting that way we have this document. We have also come to two years for this meeting and it may be time to check our membership. I do notice that we do have some that have never shown up. I believe those people may need to be replaced. I have been contacted by a number of people that have asked to be on this committee. If anyone wants to quit please let me know because if you have been showing up I will continue to have you on this committee. Aldona stated, if you do get enough to join you can rotate me off.

dl/caa/RN